EXHIBIT 50

LIST ALL EMPLOYERS/JOBS THAT YOU HAVE HAD, JOB DESCRIPTION, AND DURATION [From what date to what date]:

(Including military, summer jobs, moonlighting jobs, part-time jobs, full-time jobs).

	Employer	Job Description	Dates
1)	Space Exploration	Equipment specialist	1/12 – to present
2)	Express Manufacturing	Manufacturing Eng.	10/10 – 1/12
3)	Moore Industries	Manufacturing Eng.	9/2007 – 3/2009
4)			
5)			

LIST ALL INJURIES TO ALL BODY PARTS REGARDLESS OF WHETHER IT IS INDUSTRIAL OR NON-INDUSTRIAL:

(i.e., car accident with injury, fall injury, injury with other employers).

	Injury	Date	Employer	Body part
1)	Elbow	9/15/2006	Moore Industris	elbow
2)	Wrist	'90	Harman International	
3)				
4)				
5)				

EXHIBIT 36
Ruben Juarez
03/15/2018
Elizabeth Schmidt
CSR#13598

I. Do you have recollection of any notices posted regarding Workers' Compensation in any of the rooms of the employer's office?

(Circle)

YES Location: _____

What did the notice say? _____

(NO) I did not notice.

II. Did you notify your employer in writing (yourself or your attorney) via claim form with regard to your illness/injury?

(Circle)

(YES) How and when? _____

NO

III. Did your employer provide you with a list of all physicians on the medical provider list?

(Circle)

YES _____

(NO)

PATIENT HISTORY FORM

You must complete this questionnaire in detail in order to be seen by the doctor.
Favor de completar el questionario en detalle, antes de que el doctor lo examine.

Patient Name: Ruben Juarez Age: 45 Date: 3/25/15

PART I – JOB DESCRIPTION:

Employer: Space Exploration Length of Employment: 8 yrs

Occupation & Job Duties: (How many hours per day per each duty, and how many days per week.)

4 hours carpeter work
4 hours working with different Chemicals on conformel coat room, and wash area.

Hours per week: _____ Days per week: _____ Overtime per week: _____

Are you still working for the above company: (Yes) No

If NO, when was your last day of employment: _____

Were you fired: Yes No Why: _____

Did you quit: Yes (No) Why: _____

Were you laid-off Yes (No) Why: _____

Were you put on disability: (Yes) No Why: Medical _____

_____ and by Who: Doctor Ronel Andimen

Have you worked since that time: Yes (No)

If YES, where, when and what type of work: _____

PART II – HISTORY OF INJURY

What part of your body or what internal diseases are involved in the illness/injury (describe what happened to you, detailing when and what you were doing at that time):

I have migreine and Hed aches During the day I took many days off due to migraines and dizziness.

Give a detailed explanation of your job duties which you feel are responsible for your problem. If you suffered stress on the job, give examples of what occurred including dates and years. If you were exposed to chemicals, dust, fumes, or other hazardous materials at work describe in detail then go on to Part III (for exposure cases only).

I was

FOR ENVIRONMENTAL EXPOSURES:

DESCRIBE THE DATE(S) OF YOUR EXPOSURE:

I worked with chemicals all the time I was incharge of replacing fume filter and repair the conformal coat Equipment also order parts. For the equipment, my employer bypass the safety switch on the equipment

Did you notify or complain to anybody at work: (Yes) No

If YES, who and what was done: No thing

Did you employer send you to a doctor: Yes (No)

If YES, list the names, dates seen, and diagnosis given:

Name:	Dates:	Diagnosis:

Did you seek medical care on your own: (Yes) No

Name:	Dates:	Diagnosis:
Kacey medical	1/7/13	brain anuery sem.
Ronal Anderson	6/13	Migraines
Kacey medica	9/12	Hed aches

PART III - EXPOSURE TO HAZARDOUS MATERIALS (WORK AND/OR ENVIRONMENTAL)

(NOTE: If you were not exposed to any hazardous materials skip this section.)

Name and describe any and all chemicals which you were exposed to:

Isopropyl alcohol, 63/37 bb Solder wire
Arathane 5750, Humiseal thinner 521
Humiseal 1A33

How were you exposed to these chemicals: (Breathing, ingestion, etc)

Breathing, working with hands.
Repairing equipment and filters

How often were you exposed? (How many hours per day, days per week.)

4 to 5 Hours per day

Did you inhale these chemicals: (Yes) No

If YES, would you feel sick and if so describe what you felt: tired, Headache, Dizzie

Did you have skin contact with these chemicals: (Yes) No

How often, how many hours per day, days per week: 4-5 every day

If YES, did you experience any reaction (symptoms) and if so describe: (i.e. smell, burning of the eyes, cough, etc) nausea, dizziness, burning of eyes

If you did experience a smell, describe the smell: (i.e. pungent, like smoke, like rotten eggs, etc:

Did you develop headaches at the time of exposure (i.e. immediate, severe, hours while exposed?) yes

Did you experience shortness of breath (i.e. immediate, severe, hours while exposed?) yes I ~~beat~~ ask a coworker to go out with me for a walk

Did you experience chest pain (i.e. immediate, severe, hours while exposed)?

N-O

Did you have this type of experience of symptoms before (prior to) the described exposure?

(Describe if YES): NO

FOR WORK AND/OR ENVIRONMENTAL

How was the ventilation: Excellent Good Average (Poor) None

Ventilation was provided by: Don't Know

Were you provided with any personal protective devices: Yes (No)

If YES, what : _____Paper/Cloth Mask _____Gloves - What Kind _____

_____Respirator with Cartridge - How often were cartridges changed_____

Were you given any training on how to use the equipment: Yes (No)

Were you given any safety training: Yes (No)

Were you told that the chemicals are dangerous/hazardous: Yes (No)

What is the size of your work area: at first 20' X 10' after 30' X 15'

How many people work in that same area: 1 - 3

PART IV – CURRENT MEDICAL HISTORY

List all doctors who are currently treating/caring for you and what are they treating you for:

Name	Reason
Donal Andiman	neurology
Steven Schenkel	psychiatric
Marshak	MD

Are you currently certified for disability by any doctor? (Yes) No

If YES, what is the name of the doctor and the diagnosis: Ronald Andersen

MEDICATIONS:

List all medications which are you currently taking:

Name	Dosage	Prescribing Doctor
Topamax	100	Andersen
Depakot	500	Andersen
Wellbutrin	300	Schenkel
Pamelor	50	Andersen
Xanax	.5	Schenkel
Aspirin 81	81	Andersen

List any diagnostic studies that have been performed or treatment given to you in regards to your injury/illness, and results if known: Ecard Acad

PART V – PAST MEDICAL HISTORY (For Environmental and/or Industrial Exposures)

Have you had any previous injuries to any parts of the body involved in this claim? If yes, describe in detail:

Have you had any other work-related injuries? If yes, describe in detail: yes elbow

Have you ever been hospitalized? If yes, give hospital name, dates and reason (name of illness):

Date	Hospital	Reason (Name of Illness)
6/14	Sidars	Migraines

Have you ever had an operation (surgery)? If yes, where, when and name of operation performed:

Date	Hospital	Reason
1/8/13	Sedars	brain aneurysm

Have you ever had any car accidents? If yes, described in detail:

Dont remember

If yes, what body parts were injured:

Have you had any major adult illness? Please circle those that apply and indicate when diagnosis was first made (date and year):

Diabetes mellitus_____ High blood pressure_____

Arthritis_____ Thyroid disease_____

Tuberculosis_____ Hepatitis/Jaundice_____

Heart disease_____ Kidney disease_____

Asthma_____ Lung disease_____

Stomach ulcer_____ Cancer_____

Other (describe):

Do you have any allergies? If yes, please list including allergies to foods, medications, dust, pollens, hay fever, etc.. none

Are you currently using any herbal medicarions? If Yes, what and for how long?_____

NO

Are you currently using any over-the-counter vitamins or health food additives? If yes, what and for how long? Vitamin E

In regard to you exposure to toxic chemicals, have you seen a health care professional? If yes, when NO

If yes, are you still seeing a health care professional in regards to your exposure?_____

PART VI – SOCIAL HISTORY:

Do you currently smoke? Yes (No)

If yes, what do you smoke _____, how long have you smoked _____, and how much do you smoke per day _____ or per week?

If no, have you smoked in the past? (Yes) No

If yes, when did you stop 1/13, what did you smoke Cigarets, how long did you smoke 10+ years, and how much did you smoke 1 pack of 20 per month?

Do you currently drink alcohol? Yes (No)

If yes, how much do you drink _____ and how often_____?

If no, have you ever drank heavily in the past? Yes (No)

Do you have a history of illicit drug abuse? Yes (No)

If yes, what type of drug_____, for how long_____, and when was the last time _____?

PART VII – FAMILY HISTORY

Relation	Age	State of Health	If Dead, Cause of Death
Father	76		Natural
Mother	74		Natural
Brothers	50	Good	
	52	Good	
Sisters	60	Good	
	47	Good	

PART VIII – ENVIRONMENTAL HISTORY

Do you have any hobbies, if yes describe in detail: none

Do you have any pets, if yes, what kind and for how long? 2 dogs 5+ years

Do you currently or in the past live with anyone who is a smoker, who and for how many years? NO

Do you use any household cleaning products, how often and what? NO

Do you use fertilizers, how often? NO

Do you use insecticides, how often? NO

Do you pump your own gasoline, how often? 1 per week

Do you use solvents/paints/glues at home, if yes how often? NO

Do you reside near a chemical plant and/or toxic dump, if yes what is the name and type of plant, and how far away? NO

Did you ever reside near a chemical plant, toxic dump, major highway, or gasoline station? If yes, when, for how many years, and what distant? NO

Have you been exposed to any chemicals or hazardous materials outside of work; if yes, describe in detail? NO

PART IX – ADDITIONAL INFORMATION

Please describe any additional information which you feel is relevant to your case that has not been covered by this questionnaire.

I Get botox intectons every 3 months

PART X – PRESENT SYMPTOMS

Please indicate which symptoms you have including the frequency (daily, once a week, once a month, intermittent, constant) and the intensity (mild, moderate, severe) – if applicable.

General			How Often	Intensity	Date of Onset
Fatigue	(Yes)	No	every day	severe	
Loss of Weight			Yes (No) How Much		
Weight Gain			(Yes) No How Much 20lb		

Internal			How Often	Intensity	Date of Onset
Shortness of Breath	(Yes)	No	1 week	mild	
Palpitations	(Yes)	No	every other day	moderate	
Stomach Pain	(Yes)	No	every day	moderate	
Diarrhea	Yes	(No)			
Asthma	Yes	(No)			
Cough	Yes	(No)			
Chest pain	Yes	(No)			
Stroke	(Yes)	No		mild	
Heart Attack	Yes	(No)			
High Blood Pressure	Yes	(No)	For How Long		
History of Exposure to Fumes	Yes	(No)	What	When	
History of Exposure to Dust	Yes	(No)	What	When	

Musculoskeletal			How Often	Intensity	Date of Onset
Neck Pain	(Yes)	No	every day	severe	
Back Pain	(Yes)	No	every day	severe	
Elbow Pain	Yes	(No)			
Shoulder Pain	(Yes)	No	1 week	mild	
Diffuse Muscle Pain	Yes	(No)			

Ear, Nose & Throat			How Often	Intensity	Date of Onset
Loss of Balance	(Yes)	No	1-2 week	severe	
Dizziness (Vertigo)	(Yes)	No	1 week	mild	
Voice Changes	Yes	(No)			
Throat Irritation	Yes	(No)			
Nose Bleeds	(Yes)	(No)	1 week	mild	
Nasal Congestion	(Yes)	No	1-2 week	severe	
Noises in Ears	(Yes)	No	every other day	mild	
Hearing Loss	(Yes)	No	Which Ear both	For How Long	

Toxic			How Often	Intensity	Date of Onset
Loss of Memory	(Yes)	No	often	mild	
Tingling Sensation in Hands/Legs	Yes	(No)			
Recent Cancer	Yes	(No)	Type	When Diagnosed	
History of Exposure to Asbestos	Yes	(No)	When		
History of Exposure to Radiation	Yes	(No)	When		
History of Exposure to Toxic Chemicals	Yes	(No)	What	When	

Skin & Allergies			How Often	Intensity	Date of Onset
Skin Rashes	Yes	(No)			
Skin Itching	Yes	(No)			
Psoriasis	Yes	(No)			
Eczema	Yes	(No)			
Skin Cancer	Yes	(No)	When		
Recent Allergies	Yes	(No)	Describe		

Neurology			How Often	Intensity	Date of Onset
Headaches	(Yes)	No	1-4 per week	severe	
Dizziness	(Yes)	No	1-3 per week	severe	
Blurred Vision	(Yes)	No	1-5 per week	mild	
Numbness of Hands/Legs	Yes	(No)			

Ophthalmology			How Often	Intensity	Date of Onset
Eye Irritation	(Yes)	No	every day	mild	

Psychiatric/Psychological/Stress					
Insomnia	(Yes)	No	Crying Spells	(Yes)	No
Irritability	(Yes)	No	Suicide Thoughts	(Yes)	No
Depression	(Yes)	No	Loss of Appetite	Yes	(No)
Loss of Memory	(Yes)	No			

ADDITIONAL QUESTIONS

1. Did any doctor tell you that your problem was work-related? Y (N)
   If YES, Who _____ When _____

2. Have you had any problems with your stomach in the last 10 years? Y (N)
   If YES, Describe: _____

3. Have you had any problems with lung disease and/or asthma in the last 10 years? Y (N)
   If YES, Describe: _____

4. Any surgeries? (Y) N
   If YES, Describe: elbow, brain, wrist

5. Any previous work comp claims? (Y) N
   If YES, Describe: elbow surgery
   What were the results: on going

6. Any other previous accidents? Y (N)
   If YES, Describe: _____

HOME ENVIRONMENT

1. Please provide us with some information about your present home:
   ____ Apartment __X__ House ____ Duplex ____ Coop

2. Age of building 50+

3. Type of heating: __X__ forced hot air ____ water/steam ____ gas ____ oil

4. How many are in your household? 3

5. Are there smokers in your apartment/household? YES (NO)

6. Are there pets in your apartment/household? YES (NO)
   If yes, please specify: _____

7. Do you use pesticides or ant/roach control chemicals at home? YES (NO)

8. Do you use a humidifier at home? YES (NO)

9. Do you have wall to wall carpeting in your home? YES (NO)

10. Have there been any water leaks in your home/apartment? YES (NO)

11. Have you noticed visible stains on the walls? YES (NO)

12. Visible stains on ceiling tiles? YES (NO)

13. Does your home/apartment have a musty odor? YES (NO)

14. Have you noticed mold or mildew? YES (NO)
If yes, explain_____
_____

15. Have you hade any air quality or environmental survey done in your home/apartment? YES (NO)
If yes, what were the results?: _____

ACTIVITIES OF DAILY LIVING COMMONLY MEASURED IN ACTIVITIES OF DAILY LIVING (ADL) AND INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL) SCALES*

Do you have difficulties with activities of daily living:

ACTIVITY	EXAMPLE	NO	MODERATE	SEVERE
Self care Personal Hygiene	Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating	✓		
Communication	Writing, typing, seeing, hearing, speaking		✓	
Physical Activity	Standing, sitting, reclining, walking, climbing stairs		✓	
Sensory Function	Hearing, seeing, tactile feeling, tasting, smelling	✓		
Nonspecialized Hand activities	Grasping, lifting, tactile discrimination			
Travel	Riding, driving, flying		✓	
Sexual Function	Orgasm, ejaculation, lubrication, erection		✓	
Sleep	Restful, nocturnal sleep pattern			✓

*Adopted with changes from the American Medical Association Fifth Edition, 2004.

THE EPWORTH SLEEPINESS SCALE

Name: Ruben Juarez

Today's date: 3/25/15 Your age (years): 45

Your sex (male = M; female = F): M

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the *most appropriate number* for each situation:

0 = would *never* doze
1 = *slight* chance of dozing
2 = *moderate* chance of dozing
3 = *high* chance of dozing

Situation	Chance of dozing
Sitting and reading	3
Watching TV	3
Sitting, inactive in a public place (e.g., a theater or meeting)	3
As a passenger in a car for an hour without a break	3
Lying down to rest in the afternoon when circumstances permit	3
Sitting and talking to someone	3
Sitting quietly after a lunch without alcohol	3
In a car, while stopped for a few minutes in traffic	3

Thank you for your cooperation.